



## FACIAL PAIN PATIENT QUESTIONNAIRE

FORM # 1

Name \_\_\_\_\_

Age \_\_\_\_\_

- 1) Have you been experiencing pain in any of the following areas: eye, forehead, top of your head, temple, cheek, nose, lips, teeth, gums, jaw, surface of the ear, in front of the ear, above the ear, or in the front or middle part of your tongue? Yes \_\_\_ No \_\_\_
- 2) Are the pains that you experience sometimes very severe? Yes \_\_\_ No \_\_\_
- 3) Are the pains that you experience sometimes sharp? Yes \_\_\_ No \_\_\_
- 4) Are there times when you do not have severe sharp pains? Yes \_\_\_ No \_\_\_
- 5) Do you sometimes get a severe sharp pain all of a sudden? Yes \_\_\_ No \_\_\_
  
- 6) Do you get sharp pains that occur repeatedly in the same area of your face or head? Yes \_\_\_ No \_\_\_
- 7) Are the sharp pains primarily on one side of your face or head? Yes \_\_\_ No \_\_\_
- 8) Do you get some sharp pains in your face or head that are brief, lasting only seconds or minutes? Yes \_\_\_ No \_\_\_
- 9) Do you get sharp pains that are either electric shock or stabbing in nature? Yes \_\_\_ No \_\_\_
- 10) Is your main problem that you get episodes of sudden, brief, severe, sharp pains on one side of your face or head, that occur repeatedly in the same area? Yes \_\_\_ No \_\_\_
  
- 11) Do you have sharp pains that can be set off suddenly by light touch such as talking, chewing, brushing your teeth, touching your face, touching your head, or a light wind? Yes \_\_\_ No \_\_\_
- 12) Did you ever get significant pain relief after taking carbamazepine (tegretol) or oxcarbazepine (trileptal)? Yes \_\_\_ No \_\_\_ Not applicable \_\_\_
- 13) Did your pain first develop in adulthood (over the age of 21)? Yes \_\_\_ No \_\_\_
- 14) Do you remember any details of the first time you experienced the sharp pain in your face or head? Yes \_\_\_ No \_\_\_
- 15) Have you ever had times (weeks, months, or years) when the sharp pains have gone away completely on their own? Yes \_\_\_ No \_\_\_
- 16) Did your pain significantly improve after a neurosurgical procedure (microvascular decompression/MVD, radiofrequency rhizotomy, glycerol rhizotomy, balloon rhizotomy, Gamma Knife, or CyberKnife)? Yes \_\_\_ No \_\_\_ Not Applicable \_\_\_
- 17) On a scale of 1-10, with 10 being the worst, what is the worst your face/head pain has ever been?  
1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10 \_\_\_ (Worst)
  
- 18) Have you been diagnosed with multiple sclerosis? Yes \_\_\_ No \_\_\_
- 19) Did the pain develop soon after you developed a shingles/zoster rash in that part of your face or head? Yes \_\_\_ No \_\_\_
- 20) Did your pain occur soon after an injury to your face or head? Yes \_\_\_ No \_\_\_
- 21) Did your pain occur soon after dental work? Yes \_\_\_ No \_\_\_

22) Did your pain occur soon after a procedure to your face or head? Yes \_\_\_\_ No \_\_\_\_

23) Did your pain start soon after a stroke? Yes \_\_\_\_ No \_\_\_\_

24) Is your pain mostly dull in nature (aching, burning, throbbing?) Yes \_\_\_\_ No \_\_\_\_

25) Do you always have numbness in the area of your pain? Yes \_\_\_\_ No \_\_\_\_

26) Are you mainly experiencing pain in your deep ear, in an area too deep to touch with your finger?  
Yes \_\_\_\_ No \_\_\_\_

27) Are you mainly experiencing pain in your deep throat or back part of your tongue? Yes \_\_\_\_ No \_\_\_\_

28) Are you mainly experiencing pain in the back part of your head? Yes \_\_\_\_ No \_\_\_\_

29) Other comments: \_\_\_\_\_

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**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!!**